

The reference for this article is: Erskine, R. G. (2010). Life Scripts: Unconscious Relational Patterns and Psychotherapeutic Involvement. In R. G. Erskine (Ed.), Life Scripts: A Transactional Analysis of Unconscious Relational Patterns, (pp. 1-28). London: Karnac Books.

Life Scripts: Unconscious Relational Patterns and Psychotherapeutic Involvement

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Life scripts are a complex set of unconscious relational patterns based on physiological survival reactions, implicit experiential conclusions, explicit decisions, and/or self-regulating introjections, made under stress, at any developmental age, that inhibit spontaneity and limit flexibility in problem-solving, health maintenance, and in relationship with people (Erskine, 1980).

Scripts are often developed by infants, young children, adolescents, and even adults as a means of coping with disruptions in significant dependent relationships that repeatedly failed to satisfy crucial developmentally based needs. These unconscious script patterns most probably have been formulated, reinforced, and elaborated over a number of developmental ages as a result of repeated ruptures in relationships with significant others.

Life scripts are a result of the cumulative failures in significant, dependent relationships! Such life scripts are unconscious systems of psychological organization and self-regulation primarily formed from implicit memories (Erskine, 2008; Fosshage, 2005) and expressed through physiological discomforts, escalations or minimizations of affect, and the transferences that occur in everyday life.

These unconscious relational patterns, schemata, or life plans influence the reactions and expectations that define for us the kind of world we live in, the people we are, and the quality of interpersonal relationships we will have with others. Encoded physiologically

in body tissues and biochemical events, affectively as sub-cortical brain stimulation and cognitively in the form of beliefs, attitudes, and values, these responses form a blueprint that guides the way we live our lives. Such scripts involve a complex network of neural pathways formed as thoughts, affects, biochemical and physiological reactions, fantasy, relational patterns, and the important process of homeostatic self-regulation of the organism. Scripts formed from physiological survival reactions, implicit experiential conclusions, relational failures, prolonged misattunements and neglects, as well as chronic shock and acute trauma, all require a psychotherapy wherein the therapeutic relationship is central and is evident through the respect, reliability, and the dependability of a caringly, involved, skilled real person (Erskine, 1993).

Literature review

Eric Berne, in articulating the theory of transactional analysis, termed these unconscious patterns, schemata, or archaic blueprints a “script” (1961). Berne originally defined a script as an “extensive unconscious life plan” (ibid., p. 23) that reflects the “primal dramas of childhood”; they “are derivatives, or more precisely, adaptations of infantile reactions and experiences” (ibid., p. 116). Later, he referred to script as a “life plan based on decisions made in childhood, reinforced by parents, justified by subsequent events and culminating in a chosen alternative” (1972, p. 446).

Fritz Perls, who co-developed Gestalt therapy, also described such self-confirming, repetitive conclusions and patterns (1944) and called it a “life script” (Perls & Baumgardner, 1975) that was composed of both an “early scene” and a resulting “life plan” (Perls, Hefferline, & Goodman, 1951, pp. 305–306). Alfred Adler referred to these patterns, or schemata, as “life style” (Ansbacher & Ansbacher, 1956); Sigmund Freud used the term “repetition compulsion” to describe similar phenomena (1920g); and contemporary psychoanalytic writers have referred to a developmentally preformed pattern as “unconscious fantasy” (Arlow, 1969a, p. 8) and as “schemata” (Arlow, 1969b, p. 29; Slap, 1987). In psychoanalytic self-psychology the phrase “self system” is used to refer to recurring patterns of low self-esteem and self-defeating interactions (Basch, 1988, p. 100) that are the result of “unconscious organizing principles” termed “pre-reflexive unconscious” (Stolorow & Atwood, 1989, p. 373). In dynamic systems theory, the terms “preferred

attractor states” is used to describe repetitive patterns of organizing affective and cognitive experiences and relating to others (Thelen & Smith, 1994).

John Bowlby (1969, 1973, 1980) also wrote about unconscious relational patterns and described the biological imperative of prolonged physical and affective bonding in the creation of a visceral core from which all experiences of self and others emerge. Bowlby referred to these patterns as internal working models that are generalized from past experiences. Bowlby’s theory provides a model for understanding how an infant’s or young child’s physiological survival reactions and implicit experiential conclusions may form an “internal working model”, the antecedents of an unconscious life script.

The general psychology literature has described such schemata, unconscious plans, or life scripts as “cognitive structures” that reflect an individual’s organization of the world into a unified system of beliefs, concepts, attitudes, and expectations (Lewin, 1951); “personal constructs” (Kelly, 1955); “self-confirmation theory” (Andrews, 1988, 1989); “internalized relationship patterns” (Beitman, 1992); and as a self-reinforcing system or “a self-protection plan” referred to as both the “racket system” (Erskine & Zalzman, 1979) and the “script system” (Erskine & Moursund, 1988). Each of the authors cited above describes some aspect of unconscious relational patterns, or life scripts. Each author suggests a therapy that involves some combination of analysis, interpretation, explanation, interpersonal relatedness, or behavioural change. It is my opinion that in order to do a thorough “script cure”, it is necessary to provide a relational psychotherapy that integrates affective, behavioural, cognitive, and physiological dimensions of psychotherapy so that unconscious experience may become conscious (Erskine, 1980).

Unconscious processes

The purpose of a serious in-depth psychotherapy is the resolution of a client’s unconscious script inhibitions or compulsions in relationship with people, inflexibility in problem-solving, and deficiencies in health care. Such a “script cure” involves an internal

reorganization and new integration of affective and cognitive structures, undoing physiological retroreflections, decommissioning introjections, and consciously choosing behaviour that is meaningful and appropriate in the current relationship or task rather than behaviour that is determined by compulsion or fear or archaic coping reactions. The aim of an in-depth and integrative psychotherapy is to provide the quality of therapeutic relationship, understanding, and skill that facilitates the client becoming conscious of what was previously unconscious, so that he or she can be intimate with others, maintain good health, and engage in the tasks of everyday life without preformed restrictions.

What most people generally consider as “conscious memory” is usually composed of explicit memory—the type of memory that is described as symbolic: a photographic image, impressionistic painting, or audio recording of what was said in past events. Such explicit or declarative memory is usually anchored in the capacity to use social language and concepts to describe experience. Experience that is “unconscious” usually lacks explicit recall of an event because it is sub-symbolic, implicit, and without language. Sub-symbolic or implicit memories that are problematic or unresolved are potentially “felt” as physiological tensions, undifferentiated affect, longings, or repulsions, and pre-reflective relational and self-regulating patterns (Erskine, 2008; Fosshage, 2005; Kihlstrom, 1984). Bucci (2001) describes such physiological sensations as unconscious communication of emotional information processing. Such physiologically sensed affective memories are forms of experience that are neither linguistically descriptive nor verbally narrative. Physiological and affective experience may be revealed in body language that signals the person’s unconscious story.

I find it important to think in developmental terms and concepts, not only in terms of unconscious process as reflecting either trauma or repression. I generally conceptualize unconscious process (pre-symbolic, sub-symbolic, procedural, or implicit memory) as being composed of several developmental and experiential levels: pre-verbal; never conceptualized; never acknowledged within the family; the absence of memory because significant relational experiences never occurred; actively avoided verbalization as a result of punishment, guilt or shame; and pre-reflective patterns

of self-in-representation that are composed of attachment styles, strategies of self-regulation, relational-needs, script beliefs, and introjections (Erskine, 2008).

When we define script as a complex set of unconscious relational patterns based on physiological survival reactions, implicit experiential conclusions, explicit decisions, and/or self-regulating introjections, made under stress, we are including script patterns that are formed from explicit memory embedded in conscious or preconscious decisions of a previous developmental period. We are also describing the structured result of pre-symbolic and implicit memory, as well as unconscious procedural ways of relating to others, unconscious bodily processes, the unconscious aspects of acute trauma and dissociation, the unconscious effects of cumulative misattunement and neglect, unconscious introjection and/or pre-reflective unconscious organization of attachment styles, relational-needs, and self-regulation. Each of these antecedents of a life script requires a specific form of therapy to enable the unconscious experiences to become conscious and to facilitate the emergence of new patterns of thinking, feeling, body process, behaviour, and interpersonal contact.

Injunctions and decisions: explicit memory Berne (1972), English (1972), Steiner (1971), Stuntz (1972), and Woolams (1973) have each described script as being formed by parental injunctions and a child's acquiescence to the parents' messages. Their ideas vary in how injunctions are communicated, the critical developmental periods when a child is most susceptible to such messages, and the psychological lethality of both injunctions and the resulting compliance. Each of these theorists basically views script as an interaction of injunctions, counter-injunctions, compliance, and early developmental protocol. Generally, therapy of these script dynamics is described by these authors as consisting of explanation, illustration, confirmation, and interpretation.

Steiner (1971) put particular emphasis on the coercive power of the parents' overt and ulterior messages to lethally shape a child's life, while Bob and Mary Goulding (1978) described a list of such injunctions that formed the basis of a child making script decisions. Their examples of script decisions are examples of explicit memories wherein a scene from childhood is consciously remembered, a

corresponding parental injunction is identified, and the child's original decision to comply with the injunction is articulated. Because these memories and the resulting script decisions are explicit forms of memory, they may be amenable to a redecision therapy. As a result of this conscious awareness of how the script was originally decided, with an awareness of the lifelong consequences, and with the therapist's support, a life changing redecision is possible (Erskine, 1974).

Several examples of how redecisions are an effective form of script therapy when the script dynamics and decisions can be explicitly remembered are in Mary and Bob Goulding's book *Changing Lives Through Redecision Therapy* (1979) and their videotape "Redecision therapy" (1987), as well as in Erskine and Moursund's *Integrative Psychotherapy in Action* (1988). Allen and Allen (1972) suggested that the therapists' permissions to live differently than the parental injunctions dictate are an important element in counterbalancing or altering the effects of such script-forming memory because the permissions provide new explicit memories of an involved other person who is invested in the client's welfare. In a 1980 article, I identified the behavioural, intrapsychic, and physiological dimensions of "script cure" and established the theoretical basis for the script system, originally referred to as the racket system (Erskine & Zalcman, 1979).

The script system provides a model of how a life script is formed from explicit decisions, implicit and pre-symbolic experiential conclusions, fixated patterns of self-regulation, and/or introjections, and are actually lived out in current life, where they are expressed through behaviour, the quality of relationships, fantasy, internal physical sensations, and selected explicit memories (Erskine & Moursund, 1988). The script system describes how the life script is operational now as core beliefs about self, others, and the quality of life. The script system is composed of internal experience, perception, imagination, and conceptualization that are augmented by generalizations and elaborations that construct a

"reality" of ourselves, others, and the quality of life. It leads us to be afraid of, or angry about, what may never occur, to be deeply hurt by our anticipations, and to suffer unnecessarily in current

relationships because of the self-reinforcing nature of script beliefs. The chapter in this book entitled “The script system: the unconscious organization of experience” explains the components of the script system, provides a useful diagram, and illustrates, through a case example, how an unconscious script was operational in a client’s day-to-day life.

Implicit memory: cumulative misattunements and experiential conclusions Not all life scripts are based on parental injunctions or script decisions, contrary to what is emphasized in much of the literature on script theory. Unconscious conclusions based on lived experience account for a major portion of life scripts. Implicit experiential conclusions are composed of unconscious affect, physical and relational reactions that are without concept, language, sequencing of events, or conscious thought. Implicit script conclusions may represent early childhood pre-verbal or never verbalized experiences that, because of the lack of relationship, concept, and adequate language, remain unconscious (Erskine, 2008).

Later in life, these unconscious conclusions are experienced and expressed through a sense of unfulfilled longing or repulsion and unexpressed or undifferentiated affect. They may also be sensed as confusion, emptiness, uncomfortable body sensations, and/or a procedural knowledge for caution in relationships. These physiological sensations are subsymbolic or pre-symbolic non-verbal affective memories. In my clinical experience, many clients’ life scripts are an expression of procedural, sub-symbolic, and implicit memories of conditioned affective and sensorimotor responses, repetitive selfregulating behaviours, and preemptory, anticipatory, and inhibiting reactions that culminate in unconscious conclusions. Such implicit experiential conclusions provide a variety of psychological functions, such as orientation, self-protection, and a categorization of experiences. Implicit memory refers to the processing of subliminal stimuli, physiological sensations, and affect, as well as lived experience that, rather than becoming conscious as explicit memory, remains non-symbolized and therefore unconscious until there is an interested and involved other person who facilitates internal

contact, concept formation, and linguistic expression. Implicit script conclusions may unconsciously express developmental needs that were not satisfied, crucial relational interactions that never or seldom occurred, and the repeated failure of optimal responsiveness by primary care-takers. When primary care-takers are repeatedly distressed, anxious, or angry, crucial infancy and early childhood relational interactions may never have occurred. Examples of such crucial parent–child interactions are vital eye-to eye contact, soothing touch, or the reflective mirroring on the parent’s face as the child is either delighted or distressed (Beebe, 2005; Field, Diego, Hernandez-Reif, Schanberg, Kuhn, & Yando, 2003; Weinberg & Tronick, 1998). Such repeated parental failure to attune and respond to the developmental needs of the young child constitutes psychological neglect. These failures are not necessarily—or even usually—the result of deliberate and conscious choices on the part of care-takers. They are more often caused by parental ignorance, fatigue, or preoccupation with other concerns; or the parents may be depressed and tangled in script patterns of their own that are incompatible with meeting the child’s needs. The child, however, is unlikely to understand adult preoccupation, depression, fatigue, or script manifestations and may well fantasize intentionality when none is present. “Mum has no time for me”; “I’m not important enough”; “Dad doesn’t even look at me; he must be really mad at me because I am so bad.” Such implicit experiential conclusions, over time, form an unconscious life script. Children who grow up with, or go to school in, an environment of psychological neglect, prolonged affective misattunements, or repetitive ridicule, often fail to develop a sense of competency, selfdefinition, or the capacity to make an impact on others. Their necessary sense of security, self-value, efficacy, and agency, or selfdefinition, can be slowly and repeatedly undermined by disparaging comments, ridicule, or humiliating remarks from parents, teachers, siblings, and other children. The result may be a pervasive sense of shame and the conviction that “something’s wrong with me” (Erskine, 1994). In some situations, children and adolescents may unconsciously overcompensate by becoming extremely competent, demandingly self-definitive, or insistent on making an impact on others. The affective memories of such repetitive neglect, misattunement, or criticism (although implicit and/or procedural

rather than explicit or conscious) shape conclusions about self and a style of relationship that may linger for many years. The result of such neglect is referred to as cumulative trauma. Cumulative trauma is a delayed reaction to scores of implicit and/or procedural memories of significant relational disruptions and repeated non-verbal conclusions about self, others, and the quality of life (Lourie, 1996; Erskine, Moursund, & Trautmann, 1999).

Many personally disturbing feelings and script beliefs about self-value, belonging within a group, or the capacity to learn have their origin in the unconscious physical and affective responses to the cumulative criticism, disregard, and rejections that may have occurred in school or on the playground. As well as the early child–parent–sibling interactions, the interpersonal dynamics between peers from pre-school to university have a significant influence in forming unconscious procedural patterns and script beliefs about self, others, and the quality of membership in a group. The attitudes and behaviours of teachers may also be significant in shaping unconscious identification and/or experiential conclusions.

Cumulative trauma

Berne (1961) differentiated between “traumatic neurosis” caused by a specific trauma at a specific time in life, and “psychoneurosis”, emerging from an ongoing series of misattunements over a long period of time. Khan (1963), who coined the term “cumulative trauma” to describe the unconscious effect of repetitive negative or neglectful events, recognized that relationship failure is the primary cause. He writes, “Cumulative trauma is the result of the breaches in the mother’s role as a protective shield over the whole course of the child’s development, from infancy to adolescence” (p. 290).

Even though it can lead to the same sort of script pattern typical in the cases of acute trauma, cumulative trauma is initially developed in a different way. Rather than protecting oneself from the pain of a specific incident, the person must deal with a slow but constant accumulation of tiny, almost insignificant misattunements, hurts, neglects, or criticisms. Over time, the person comes to accept this pattern as simply a part of the way he/she/others/life has to be. Like the slow drip of calcium-laden water that builds over the years into a stalactite or stalagmite, the drip of cumulative trauma results in the slow building up of script beliefs in the caverns of

one's mind. There is often very little to point to in later life, no way to say, "That is what happened to me, and this is how I reacted." Each early childhood neglect and misattunement in and of itself may not be traumatic, but they lead to script-building consequences cumulatively and are recognized (if one eventually becomes conscious of the pattern and understands the influence) only in retrospect.

Lourie (1996) defines cumulative trauma as "the totality of the psychological failures, or misattunements, that a child endures from infancy through adolescence and beyond" (p. 277). When parents are not consistently contactful, or do not resonant with the child's expression of affect, they fail to acknowledge or validate the child's relational-needs. Children whose affective expressions and relational-needs are not acknowledged and validated have no social mirror in which to view themselves, and, therefore, lack the necessary relational partner whose mirroring response or explanation may provide an articulation and possible reversal of the emerging script conclusions. Cumulative misattunement to the child's emotional expressions, developmental needs, and emerging relational patterns and conclusions interferes with the child's opportunity to discover and create themselves as unique and emotionally supported individuals within a matrix of social relationships (Trautmann & Erskine, 1999).

"A severe consequence of cumulative trauma", says Lourie (1996), "is the loss of trust in and knowledge of self resulting from the vast assortment of parental misattunements . . . that the child endures" (p. 277). These children may conclude that at their core they are inadequate and unlovable; they hide this conclusion and resulting belief from others—and from themselves—and the result may be an inability to form a lasting and satisfying intimate relationship. They may withdraw from the company of others or may chain themselves on a treadmill of endless and superficial social activities; they may constantly demand attention and caretaking; or they may make themselves over-responsible for the needs of those around them. As a result, there is a loss of both internal and interpersonal contact (Erskine & Moursund, 1988; Perls, Hefferline, & Goodman, 1951). The person may lose contact with his or her own sensations, feelings, needs, thoughts, or memories, as well as interrupting

interpersonal contact with others. All of these contact interrupting cognitive and/or behavioural manifestations of the experiential conclusions serve to distract the person from the implicit memory of loneliness, emptiness, and misattunement that the child may have actually experienced. These script-based beliefs, fantasies, and behaviours do not satisfy the unrequited childhood relational-needs (and, over the long run, actually prevent the satisfaction of current relational-needs), but the internal and external interruptions to contact distract from an awareness of such needs for a time, dulling the pain and providing temporary relief (Moursund & Erskine, 2004).

Interruptions to contact (such as denial, disavowal, desensitization, retroreflection, introjection, relational distancing) reduce the awareness and distress of relational failure. They may temporarily alleviate anxiety and the memory of neglectful or traumatic events while distracting from the sense of interpersonal loss. They are “normal” in that they are human, adaptive reactions to repeatedly unmet biological and relational-needs. When used repeatedly, or to an extreme degree, contact interruptions interfere with the important integration of affect, physiology, and memory by creating perceptual distortion, emotional confusion, limitations in information processing and a lack of awareness of relational-needs.

Relational needs include many dimensions of interpersonal contact and attachment, such as affective and rhythmic attunement, mutual influence and validation, and the shared use of language to communicate phenomenological experience. Some of the many dimensions of relational-needs are: a sense of security in relationship; validation of one’s affect and internal experience; a sense of reliance, dependability, and consistency from a significant other person; a shared experience; self-definition; the capacity for having an impact in relationship; to have the other initiate; and to express one’s appreciation and gratitude (Erskine, 1998; Erskine & Trautmann, 1996; Erskine, Moursund, & Trautmann, 1999). The experience of prolonged neglect of these relational-needs interrupts internal contact and forms the core of implicit script conclusions.

Body script

Life scripts are often encoded biochemically within bodily tissue. In almost every case of script, whether formed by explicit decisions, unconscious experientially-based conclusions, or survival reactions, there may be a corresponding biochemical and physiological response within the body. Because of the intense sub-cortical brain stimulation and biochemical activity at the time of script conclusion or decision, the person may be unable freely to express emotions and act in accordance with needs (Damasio, 1999). The amygdala and limbic system of the brain are overwhelmed and the natural physiological and affective expression may be turned inward—a physiological retroflexion (Perls, Hefferline, & Goodman, 1951). This physiological retroflexion, which is paired with a lack of safety, an unexpressed protest, unexpressed fear, or a shutting down of the body's natural action, is often maintained years later as a physiological structure, habitual action, or inhibition of expression. When misattunement and neglect from significant others have persisted over time, these inhibiting retroflexions actually become the person's physiological sense of "this is me". The stiff neck, the muscle pain in the shoulders, the grinding of teeth, the clenched fist, is what the client has always known. These manifestations of body scripts are encoded as physiological, as well as psychological, structures.

Life scripts that have an origin in either acute or chronic trauma, or even cumulative neglect, are almost always physiological—the script is within the body—as a result of the survival reactions within the hypothalamic–pituitary–adrenal axes of the brain and the corresponding muscular tension (Cozolino, 2006). These psychological survival reactions often reoccur as automatic and sudden responses that involve various organs, muscle groups, or even the total body, because of the brain's stimulation of neurotransmitters and hormones that affect every organ system (Van der Kolk, 1994). The sudden reactivation of physiological survival reactions are not conscious (until after they have occurred) because the associational networks of the brain have become "fear conditioned" and are paired with other script dynamics such as core script beliefs, behavioural patterns, and a conglomerate of emotional memories (LeDoux, 1994).

When stress or neglect occurs early in life, is prolonged or extreme, brain functioning and behaviour become organized around fear, rigidity, and an avoidance of stimulation and exploration (Cozolino, 2006). Several writings and research reports on early child development support the idea that script is formed by sub-symbolic physiological survival reactions, self-regulation patterns, and unconscious conclusions in response to the quality of both early and ongoing significant relationships (Beebe, 2005; Bloom, 1997; Field, Diego, Hernandez-Reif, Schanberg, Kuhn, & Yando, 2003; Lyons-Ruth, Zoll, Connell, & Grunebaum, 1986; Tronick & Gianino, 1986; Weinberg & Tronick, 1998). The earlier the misattunement, neglect, or physical and emotional trauma, the more likely the script will be within the body and not accessible through language or a narrative form of therapy and, in many cases, not available to consciousness.

An effective and complete psychotherapy aimed at script cure must identify and ameliorate the physiological restrictions, inhibitions, and body tensions that interfere with affect, expression of current relational-needs or the maintenance of good health. When I engage in body script therapy, the treatment goal is to energize the body tissue that was inhibited and rigidified when developmentally based physical and relational-needs were unsatisfied and primal feelings were repressed. Body script therapy may be the entrance into doing affective or cognitive therapy as a means of bringing unconscious experience to awareness, or it may be a concluding step in the treatment of specific script restrictions. Interventions at the level of body script include those approaches that lead to somatic change, such as attentive awareness to bodily process, gentle touch, deep massage work, tension relaxation, or proper diet, exercise, and recreational activities that enhance the flow of energy and movement of the body.

Script cure at the physiological level is a letting go of tensions, body armouring, and internal restrictions that inhibit the person from living life fully and easily within his or her own body. Changes in body script are often evident to an observer as a more relaxed appearance, freer movement, increased energy, and an established weight level that is appropriate for the person's frame. After experiencing an effective psychotherapy orientated to resolving

physiological restrictions, inhibitions, and retroflection, people report having a greater sense of vitality, an ease of movement, and an increased sense of well-being.

A description of the methods that are useful in the cure of physiological aspects of life scripts is beyond the scope of this chapter. However, it is the responsibility of the psychotherapist to focus on bodily processes, retroflection, physiological survival reactions, early childhood coping strategies (such as freezing, flailing, turning away), and even minute movements or silences. Each of these may be an expression of a physiological response to relational disruptions that are imbedded in a life script.

Introjection: whose script is it?

Introjection is an unconscious self-protective identification with aspects of the personality of significant others that occurs in the absence of full contact, where crucial needs were unfilled in a dependent relationship. Introjection provides a psychological compensation for unsatisfied relational-needs and disruptions in essential interpersonal contact. An external relational conflict is avoided, but the conflict is, instead, internalized, where it is seemingly easier to manage (Perls, 1978). Therefore, introjection is often accompanied by physiological survival reactions and retroflections. (Perls, Hefferline, & Goodman, 1950).

Many aspects of a person's life script may be the result of introjecting parents', teachers', or significant others' feelings, bodily reactions, attitudes, script beliefs, behaviours, and relational patterns. It may be imperative in a thorough treatment of life script to identify the origin of the client's depression, disappointments, bitterness, spitefulness, or internal criticism. Are such attitudes, beliefs, anticipations, and behaviours the result of one's own life experiences, conclusions, and decisions? Or are these the assumed thoughts, feelings, behaviours, and coping systems of a significant other that have been introjected? Is the script the result of a self-criticizing defence against awareness of the internal influence of an introjection (Erskine, 1988)? The therapeutic explanation and identification of the many aspects of introjection and the necessary psychotherapy are important in the treatment planning and selection

of methods that lead to script cure. The specific methods in the treatment of introjection or vehement self-criticism and actual case examples are detailed in several other writings (Erskine, 2003; Erskine & Moursund, 1988; Erskine & Trautmann, 2003; Erskine, Moursund, & Trautmann, 1999; Moursund & Erskine, 2004). In a thorough psychotherapy aimed at script cure, it may be essential that the psychotherapist addresses the internalized elements of the personality of significant others and either provides a therapeutic interposition or a complete decommissioning of the introjection (Berne, 1961).

Transferences of everyday life

Although life scripts may be formed at any developmental age, in my clinical experience, tenacious life scripts are not formed by explicit decisions alone, but are most commonly formed from a composite of implicit experiential conclusions, survival reactions, and introjections. The implicit memories of these script-forming conclusions, survival reactions, and introjections are not directly available through the client's explicit memory or in any organized narrative about his or her early life experiences. Such early memories and implicit conclusions are revealed through bodily reactions, pre-reflective relational patterns, transference within the therapeutic relationship and, most commonly, through the transferences of everyday life (Freud, 1912b). The hurts and angers with family or friends, or the fearfully anticipated reactions of co-workers, the disregard for one's health or general welfare, and the habitual worry, repetitive fantasies, or obsessions are examples of the unconscious transference of early emotional memory into the current events of everyday life.

Berne defines scripts as "transference phenomena" that may be re-enacted over a lifetime and that are derived and adapted from "infantile reactions and experiences" and the "primal dramas of childhood" (1961, p. 116). In an effective psychotherapy, it is often necessary for the psychotherapist to help the client construct a narrative of his or her early emotional and relational experiences in order to gain an understanding and resolution of his or her transference reactions. This is often accomplished through the therapeutic method of implication, wherein the therapist co-constructs with the client meanings for his or her experience and provides

both concepts and a sense of the significance to the affective and physiological memories. Transference, both within the therapeutic relationship and the course of everyday life, is often an expression of “the first traumatic experience, the protocol” and the cumulative “later versions or palimpsests” (ibid., p. 124) of the script—the unconscious experiential conclusions.

Transference within a therapy relationship, and, even more commonly and frequently, in the relationships and activities of everyday life, is an expression of the effects of previous relational disruptions and failures, as well as an expression of relational needs and a desire to achieve intimacy in relationships. It is an unconscious enactment of past affect-laden experiences and psychological functions, such as self-regulation, compensation, or self-protection (Brenner, 1979; Erskine, 1993; Langs, 1976). Transference is a manifestation and expression of the unconscious dynamics of life scripts.

Elizabeth: an unconscious search for love

The following case example of Elizabeth’s unconscious search for her mother’s love is an illustration of how her life script was the result of implicit experiential conclusions, cumulative parental misattunement to her affect and relational-needs, and an explicit script decision. In Elizabeth’s psychotherapy, we explored her bodily sensations and physiological survival reactions and how she may have introjected her mother’s depression when she was an infant and pre-school child. My phenomenological and historical enquiry, affective, developmental, and rhythmic attunement, and therapeutic inference revealed that the very young Elizabeth was deeply affected by her mother’s depression. One of our therapeutic tasks was to separate her own unconscious reactive early childhood depression from the introjected depression of her mother and to provide a sensitive therapy to both aspects of the depression. Our psychotherapy focused on making her unconscious affect and physiological experience conscious and attending to her developmental needs for a dependable, consistent, and involved relationship. Interwoven through this case illustration are some examples of how the script was manifested in everyday life and the necessity for a relational and integrative psychotherapy aimed at achieving a script cure.

Elizabeth looked like a lost child when she began her psychotherapy. She described herself as “empty, lost, and confused”. In her initial sessions, she wondered if she had “inherited a depression” because she often felt “so empty inside”. She dressed poorly, even though she had a well-paying job. Her clothes neither fit her well nor did the colours or patterns match. Her hair often looked uncombed and in need of a cut. My early impressions of Elizabeth were that she was a neglected and unloved child.

Elizabeth was married, and described her relationship with her husband as “we mostly just live together” without much physical contact. She saw no problem with her marriage, because she and her husband often did things together, such as going to many cinemas and she was pleased that he did the grocery shopping and all the cooking.

Elizabeth’s father once angrily told her that Elizabeth’s mother was “depressed” and that the depression was why her mother “abandoned” the family when Elizabeth was five years old. Her father would get angry and critical if Elizabeth ever asked any questions about her mother. There were no photos of Mother, nor was there any contact with members of Mother’s family. Mother ceased to exist. There was never any conversation between Elizabeth and her father about her mother’s disappearance. Elizabeth’s father never made any acknowledgement of Elizabeth’s emotional loss of her mother and certainly no validation of her intense grief and need to be loved. She unconsciously concluded during her childhood years that her feelings, emptiness, and longings meant “I’m a bother to people”.

Elizabeth could not consciously remember anything about her mother. She could not recall what her mother looked like. Father admitted that he had destroyed all of the photographs of Mother, including wedding photos and photos of Elizabeth with her mother when she was a baby and pre-school child. The result was that she walked the streets of New York City searching for a face that could be her mother’s. Elizabeth’s longing for love was unconscious. She was only aware of the emptiness inside and of a desperate “search”. She had no consciousness of her needs for mothering and

loving. Whenever I enquired about any relational-need Elizabeth might have, or about her mother, she would unconsciously stroke her lips or hair. I recognized these unconscious gestures as a need for security and early mothering, even though she could neither think about nor verbalize her needs. Her self-soothing initially had no meaning to her until we talked about her lip and hair stroking many, many times and related the self-soothing to the need for mothering affection and soothing touch. Even though she had no consciousness of her need for mothering, she acted out her unconscious needs in the transference through her helplessness and demeanour of neglect.

Elizabeth found it incomprehensible that I would think about her between sessions. She had no sense that she could make an impact on me. Unlike other clients, Elizabeth never missed me when I travelled. She often said that she did not know what to talk about in our sessions. She expected me to be critical of her. In our early sessions, she was able to identify this expectation of my potential criticalness and related it to explicit memories of her father's "constant criticism of everyone". During this phase of therapy, she became conscious of having made an explicit script decision between the ages of ten and twelve to be cautious of everyone because "people are critical".

Elizabeth could recall some stories and explicit memories of interactions with her father, particularly about special events or vacations where they did activities together, such as going to football games or swimming, but Elizabeth had no capacity either to conceptualize or talk about feeling cared for in a relationship, nor did she have any awareness of her relational-needs. During the psychotherapy, Elizabeth's implicit memories were transformed into explicit stories.

Elizabeth described how she would tighten her body in bed rather than snuggle into her husband. Through ongoing phenomenological enquiry about her sensations, affect, and internal images, she eventually said, "I think I could not snuggle into my father. His embrace was hard and he was always in a hurry or critical." This comment was the opening in our examining several transference reactions in her marriage and also to the realization of her disavowed

anger at her father for the absence of loving in her family. She began to wonder about the cause of mother's alleged depression and why the mother might have left the family.

I never did any therapy with Elizabeth's possible introjection of her father's attitudes or feelings. If I had had the opportunity, I would have investigated if it was also he who was depressed, particularly after his wife had left him when Elizabeth was five years old. It is possible that his "constant criticism of everyone", his destroying all the photographs, and his not ever speaking about Elizabeth's mother was an expression of either his depression or bitter resentment or both.

By the third year of therapy, I gently and persistently enquired about Elizabeth's early relationship with her depressed mother. I felt an intense tenderness for the little girl she once was and an attunement to the needs of a neglected baby and pre-school child. I realize that I kept my eyes on her all the time, particularly on her eyes whenever I caught a glimpse of her downward- or inward looking gaze. I experienced a simple innocence in her and a willingness to "please at any cost". My tender comments and reflections of her possible childhood needs were met with confusion and/or distracting comments—comments unrelated to her vulnerability, needs, or relationship with her mother. These juxtaposition reactions included Elizabeth's disregard of my caring gaze, words of tenderness, or descriptions of the relational-needs of a young child—a juxtaposition between what she desperately needed from both parents and for which there were neither implicit nor explicit memories. Her deflection and distancing comments also expressed the unconscious script belief, "I don't need anything".

Elizabeth had neither explicit nor implicit memory of either mother's or father's vital eye contact, caring gestures or words, or any attention to her loss, vulnerability, or needs. Elizabeth had no concept of relational-needs, only the longing, empty searching for "something". Her internal working model, an implicit memory—or, in this case, her non-memory because the events had never occurred—shaped her sense of confusion, distress, and emptiness in response to each of my caring comments. She could not be conscious of the cumulative trauma of what never happened but what should have happened in a loving family relationship. Instead, her

unconscious conclusion built up over many years of neglect was “I’m not loveable”.

My psychotherapy with Elizabeth often focused on her physical sensations as an unconscious expression of possible needs that were not responded to and remained unsatisfied while she was a child. I was particularly sensitive to her unconsciously expressed needs for security, validation, and to rely on someone who is consistent, dependable, and attuned to her affect. The relational-need to make an impact on a significant other, or to have the other initiate any caring gestures, was conspicuously absent in her sparse narrative about her family life. Each of these needs became an integral part of our psychotherapy together. I repeatedly identified, validated, and appreciated these essential needs.

Interwoven in our therapy was a careful therapeutic attentiveness to Elizabeth’s sense of shame—a shame she felt with her school peers about coming from a one-parent family and having a mother who had disappeared. Elizabeth described how she had often lied to the other children by telling them about a dramatic childbirth in which her mother had died heroically.

Through a great deal of phenomenological enquiry and explanation of the normal needs of children, and, by inference, her own needs, Elizabeth and I co-created a story that began to make sense to her of her longings and self-neglect, her frequent soothing gestures, her emotional discomfort with both eye contact and affectionate touch, and her endless search for a mother’s love.

My affective and developmental attunement served to continually inform both of us of the unrequited needs of a young child. The tenderness, kindness, and gentleness that I strove to bring to the therapy provided an involved therapeutic relationship—a relationship that facilitated Elizabeth’s valuing, for the first time in her life, her vulnerability and needs. At the same time, I was facilitating her identification and understanding of the unconscious script conclusion that “life is an empty search”. Putting this unconscious conclusion

into words in a number of sessions became important to Elizabeth, because it gave meaning to her longings, emptiness, and search for her mother. She slowly became secure enough in our therapeutic relationship to finally grieve for her lost mother and to acknowledge her anger at her father's criticalness and emotional distancing. Her appearance improved slowly over time. Periodically, she was dressed in something new that fitted her attractively. One day, in the fifth year of therapy, she surprised me with a new, stylish haircut and colouring—an adult form of self-soothing. She experimented in asking her husband to do things for her and to be more affectionate. As a result, she reported an increased intimacy with her husband. She no longer searched for her lost mother's face on the streets of New York City; her unconscious search for love became conscious. She experienced being loved.

Psychotherapeutic involvement

For clients who are similar to Elizabeth, script cure necessitates a relational psychotherapy that addresses affect and cognition, developmental

and current needs, the transferences in everyday life, behaviour, and fantasy, physiological reactions and health maintenance, and the psychological functions that perpetuate continual reinforcement of script beliefs. Throughout Elizabeth's psychotherapy I focused on many of her attempts at avoidance. We explored how each intrapersonal interruption to contact signalled a significant interruption to internal contact with feelings, bodily sensations, needs, memories, or longings. My therapeutic involvement included periodically identifying when and how I was misattuned to her. She was surprised when I took responsibility for my therapeutic errors (Guistolese, 1997). Both the content and affect of my communication were such juxtapositions with how her father related to her (Erskine, 1993).

My initial impression of Elizabeth as a neglected and unloved child, and her descriptions of the relationship with her husband, are only two examples of the unconscious communication of a life script through the transferences of everyday life. Her husband represented the longed-for good mother who did all the grocery shopping and cooking while making no sexual demands. In the early phases of the psychotherapy, there appeared to be no transference

with me. She was not bothered when I went away. Yet, the apparent absence of transference was the transference! Elizabeth's avoidance of interpersonal contact with me was a repeat of how she coped with the feelings, relational-needs, and significant dialogue that was absent in her relationship with father. Elizabeth required an involved psychotherapist who was sensitive, authentic, and fully present.

It is necessary in a relational and integrative psychotherapy that the psychotherapist provides an ongoing enquiry into the client's phenomenological experience of each developmentally dependent relationship, which includes the influence of parents, family members, teachers, and peers, on forming his or her relational patterns and script beliefs. Such a therapeutically useful phenomenological enquiry can only occur in an atmosphere of the psychotherapist's sustained attunement to the client's affect, rhythm, developmental level of functioning, cognitive style, and relational-needs.

In the case of Elizabeth, Father did not acknowledge or validate her grief over the loss of Mother. There was no conversation, no soothing gestures, no way for Elizabeth to resolve her grief and retain any precious memories of Mother. The photographs were destroyed and there was no relationship with the mother's family. As a result of the unacknowledged mother–daughter relationship and resulting grief at the loss of the relationship, Elizabeth lost conscious memory of anything about her mother. In the psychotherapy, I continually brought up the absence of mother and enquired about Elizabeth's grief and the missed opportunities between a mother and daughter. I often explained what a growing girl needs from a mother, and would then enquire further about her feelings, bodily sensations, associations, and fantasies. We began to co-create a narrative about her previously unconscious and untold life story—a story that had been acted out by searching for mother's face.

Conclusion

In the psychotherapy of life scripts, it is important that the psychotherapist understands and appreciates that life scripts are a desperate and creative attempt to self-regulate while managing and adjusting to the failures that occurred in significant and dependent

relationships throughout life. Scripts are a self-protective way of compensating for what was, and may still be, missing in relationship while ensuring a semblance of relationship. The process of script formation is relationally interactive and personally creative—an assimilation and accommodation (Piaget, 1954) to the neglects, misattunements, relational requirements, or even demands, of significant others (Block, 1982). It involves a generalization of specific experiences and an unconscious anticipation that these generalized experiences will be repeated throughout life.

The psychotherapy of life script necessitates an understanding and appreciation of each individual's unique temperament as well as these creative adjustments, coping and adaptive styles, and resulting internal and external interruptions to contact. The psychotherapist's sensitivity to, and understanding of, physiological survival reactions, unconscious experiential conclusions, contact interruptions, and the unique relational nature of the therapeutic involvement is essential for an in-depth psychotherapy that focuses on the resolution of archaic relational patterns, current relational disturbances, and fixated systems of psychological organization. An effective relational psychotherapy includes the psychotherapist's acknowledgement of the client's psychological experiences, validation of his or her affect and attempts at meaning making, and normalization of the client's developmental attempts to adapt and cope with family and school stressors. It also provides an interested, involved, and caring presence of a real person who communicates to the client that he or she is valued.

Script cure is the primary goal of an integrative psychotherapy. Script cure is the result of an integration of affect, cognition, and physiology so that important aspects of one's life are available to consciousness, and that behaviour, health maintenance, and relationships are the result of flexible choice rather than compulsion or inhibition. People who are no longer functioning in a restrictive life script report that they have the capacity to express themselves in a contactful way in relationship; internally they are emotionally stable because they are both unfettered by predetermined and restrictive script beliefs, and they are aware of their current needs in relationship. They have a sense of self-definition, agency, and authenticity; their behaviour is both contextual and sensitive to

other people's relational-needs. Interpersonally, they are conscientious, gracious, curious, personable, and intimate.

Life scripts formed from a composite of physiological survival reactions, implicit experiential conclusions, relational failures, prolonged misattunements, and neglects require a psychotherapy wherein the therapeutic relationship is central and is evident through the respect, reliability, and dependability of a caringly involved, skilled real person. Life scripts are the result of cumulative failures in significant and dependent relationships and, therefore, an involved relational psychotherapy is necessary for script cure.

Postscript

A detailed description of the philosophy, therapeutic perspective, ethics, and methods of a relational and integrative psychotherapy suitable for facilitating a cure of these tenacious life scripts is described in *Integrative Psychotherapy in Action* (Erskine & Moursund, 1988), *Beyond Empathy: A Therapy of Contact-in-Relationship* (Erskine, Moursund, & Trautmann, 1999), and *Integrative Psychotherapy: The Art and Science of Relationship* (Moursund & Erskine, 2004).

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